PONDEROSA

SUMMIT Medication Form

⇒ ***DEADLINES: #1 May 27th or #2 June 27th***

⇒ ***Turn in this completed and signed form to your Grouop Leader***

PARENTS: ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINERS AND NOT EXPIRED! Please read the following carefully

Over-The-Counter Medications (OTC) Standing Orders are given to Ponderosa by a physician for "as needed" situations, and parents give permission for these via CampDoc. ***HOWEVER****, if a child takes an OTC on a regular basis,* ***THIS FORM IS REQUIRED***, as it is treated like a prescription (i.e. Zyrtec daily for allergies).

Prescription Medications must come to camp in container labeled with **(1)**Child's Name, **(2)** Name of medicine, **(3)**Time of day to be given, **(4)** Dosage, **(5)** Date medicine is to be stopped, **(6)**Licensed Healthcare Provider's Name, and **(7)**Pharmacy Name/Phone Number.

Camper Name: _____

Church Name: _____

Week Attending: ☐ SUMMIT Week #1 June 13-17, 2022

☐ SUMMIT Week #2 July 11-15, 2022

The parent/guardian of _____ asks that the licensed health personnel at Ponderosa give
(Child's Name)

medication/s listed below by our Healthcare Provider to my child, according to the Healthcare Provider's signed instructions. By signing this document, I give permission for my child's healthcare provider to share information about the administration of my child's medication with licensed health personnel at Ponderosa delegated to administer medication.

_____ _____ _____

Parent/Legal Guardian's Name | Parent/Legal Guardian Signature | Date

_____ _____

Work Phone | Home/Cell Phone

Medications to be Administered at Ponderosa

Child's Name: _____ **Birthdate**: _____

#1 Medication: _____ Dose: _____ Route: _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

#2 Medication: _____ Dose: _____ Route: _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side Effects to Report: _____

Starting Date: _____ Ending Date: _____

Primary Care Provider's Name | Primary Care Provider's Phone Number

_____ _____

Please attach additional forms as necessary.